

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00426

Reg. Dist. No. 100

1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war.

3. (a) FULL NAME

3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

MEDICAL CERTIFICATION

20. DATE OF DEATH

19. 48, at 9 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

11-27-1947, to 1-4-1948

and that I last saw him alive on 12-29-1947

Immediate cause of death

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed 1-5-48

17.

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

19.

Registrar



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a

00427

CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH:

County..... Charles
 City or town..... Lablata
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Phys. Res. Hosp.
 How long in hospital or institution?..... 11 days

3. (a) FULL NAME

Joseph Burroughs

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

Anne Swann

7. Birth date of deceased (mo., day, yr.)

1877

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

71..... hrs. min.

9. Birthplace

St Mary's Co Md.

10. Usual occupation

Farmer

11. Industry or business

Unknown

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

(Burial, cremation, or removal) Which?

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19. 1-31

(Date rec'd by registrar)

19. 48

Jalia H. Perry

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md.

County

Charles

City or town

Lablata

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

1-31

19. 48

at 11 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1-20 19. 48 to 1-31 19. 48and that I last saw him alive on 1-30 19. 48

Immediate cause of death

Uremia, Nephritis

Due to

Gen. Arterio Sclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Address

M. D. or other

Date signed 1-31-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00428

Reg. Dist. No.

104

1. PLACE OF DEATH:

County..... Charles
 City or town..... Farmersville, Md.
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Sophia Donley

3. (b) Social Security Number

4. Sex

Female

5. Color or race

Col

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

Joseph Donley

7. Birth date of deceased (mo., day, yr.)

month Unknown 1897

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

70Unknown

hrs.

min.

9. Birthplace

Farmersville, Md.
(town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

MOTHER
FATHER

12. Name

John Jenkins

13. Birthplace

Unknown

14. Maiden name

Unknown

15. Birthplace

16. Informant

Joseph Donley, Jr.
Issue, Md.

Address

17. (Burial, cremation, or removal, Which?)

Burial

Date thereof

1/8/48
(month) (day) (year)

Cemetery or crematory

Holy Ghost Cemetery

Location

Issue, Md.

18. Funeral director

Hunt and Ryan

Address

Waldorf, Md.

19. (Date rec'd by registrar)

1/7/48Willie's Issue

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland

County

Charles

City or town

Farmersville
(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH

1-6-1948, at8:30 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept. 14-1947, to1-6-1948

and that I last saw her alive on

12-30-1947

Immediate cause of death

apoplexy

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

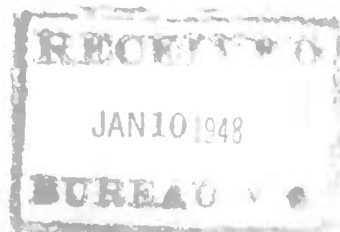
23. SIGNATURE

J. L. Higdon

M. D. or other

Address

Wayside, Md.Date signed 1-7-48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00429

CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH:

County... Charles
City or town... La Plata, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 22 yrs
Hospital, institution, or street address where death occurred:
Physician: Memorial Hospital
How long in hospital or institution? 22 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State... Maryland County... Charles
City or town... BRYAN TOWN
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION)
2.(a) If veteran, name war. _____

3. (a) FULL NAME

WILLIAM M

GRAVES

3. (b) Social Security Number

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

W

6. (b) Name of husband or wife

MARY A. GRAVES

7. Birth date of deceased (mo., day, yr.)

February 25, 1869

6. (c) If alive, give age _____ years

8. AGE:

78

10

15

hrs. min.

9. Birthplace

MARYLAND
(Town, county, and state)

10. Usual occupation

RETIRED PRINTER

11. Industry or business

FATHER

12. Name

John Waveren Stone

13. Birthplace

M.D. St. Mary's Co.

MOTHER

14. Maiden name

Elizabeth Jarboe

15. Birthplace

M.D. St. Mary's Co.

18. Informant

MRS. PETER BECKER, JR.

Address

3209 - Stephen Place
E.E.M.D.

17. Burial

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Int. Olivet Cemetery

Location

Washington, D.C.

18. Funeral director

James T. Ryan, Inc.

Address

311 Penn. Ave., S.E.

19. Date rec'd by registrar

1-10-48

John H. Pusey

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

10 January 1948 at 8:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

27 August 1947 to 10 January 1948

and that I last saw him alive on 9 January 1948

Immediate cause of death Arteriosclerotic heart failure

DURATION

1 yr.

Due to Arteriosclerosis

years

Due to generalized senility

Other conditions marked arthritis

(Include pregnancy within 3 months of death)

Major findings of operations

_____ Date of op. _____

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE

Dr. Woody, M.D.

Address La Plata, Md. Date signed 10 Jan 48

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctness of the information is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 17 1948

ST. LOUIS

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

462

01590

CERTIFICATE OF DEATH

Reg. Dist. No. 106

1. PLACE OF DEATH

County Charles
 City or town Indian Head
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Life
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Charles
 City or town Indian Head
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)
 2. (a) If veteran, name war

3. (a) FULL NAME

Carrie Hill

3. (b) Social Security Number

4. Sex F 5. Color or race C 6. (a) Single, married, widowed, or divorced married
 6. (b) Name of husband or wife Alexander Hill
 6. (c) If alive, give age 74 years
 7. Birth date of deceased (mo., day, yr.) 1978

8. AGE: Years 69 Months Days If less than one day hrs. min.

9. Birthplace Charles Co. Md.
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name Louis Branson

13. Birthplace Unknown

14. Maiden name Mary E. Subman

15. Birthplace Unknown

16. Informant Charles A. Branson

Address Indian Head, Md.

17. Burial (Burial, cremation, or removal) Which? Burial Date thereof Jan. 19, 1948
 (month) (day) (year)

Cemetery or crematory St. Charles

Location Glymont Md.

18. Funeral director Walter Penn

Address Mason Springs Md.

19. 1/18 48 Odey Price
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 15, 1948 at 3 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 20, 1948 to Jan 14, 1948

and that I last saw him/her alive on Jan 14, 1948

Immediate cause of death Intestinal Carcinoma

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Antepoxy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Geo. C. Bicknell Md.
 M. D. or other

Address Marbury Md. Date signed Jan 15 48

RECEIVED

FEB 14 1948

U.S. DEPT. OF JUSTICE

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct use of this form is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

9400

00430

CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH

County Charles
 City or town La Plata
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Physicians' Memorial Hospital
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Charles
 City or town Paper Creek
 (If outside city or town limits, write RURAL and give nearest town)

Street No. _____
 (If rural, give LOCATION)

2.(a) If veteran, name war _____

3.(a) FULL NAME

HENRY H. HOYME

3.(b) Social Security Number

4. Sex

M.

5. Color or race

W.

6.(a) Single, married, widowed, or divorced

M.6.(b) Name of husband or wife Grace Hutchins Hoyme

7. Birth date of deceased (mo., day, yr.)

Sept. 5, 1968

6.(c) If alive, give age _____ years

8. AGE:

79

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

Chester, Va.
(Town, county, and state)

10. Usual occupation

Retired - R.R. Agent

11. Industry or business

FATHER

12. Name

William Hoyme

13. Birthplace

Washington

14. Maiden name

Charlotte Elizabeth Cooper

15. Birthplace

Washington, D.C.

16. Informant

Mr. W. H. Hickory

Address

Thurman, Md.

17.

(Burial, cremation, or removal. Which?)

Date thereof

1/9/48
(month) (day) (year)

Cemetery or crematory

Christ Church

Location

Wayside, Md.

18. Funeral director

Hunt & Ryan

Address

Woods, Md.

19.

(Date rec'd by registrar)

19 48Julia H. Tracy

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7 January 1948 at 11:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

4 January 1948 to 7 January 1948and that I last saw him alive on 7 January 1948Immediate cause of death Coronary thrombosis

DURATION

DaysDue to arteriosclerosisyears

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations none

Date of op.

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work?

23. SIGNATURE W. Wooddy, MD

M. D. or other

Address La Plata, Md.Date signed 7 Jan 48

RECEIVED

JAN 15 1948

ST. LOUIS

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00431

Reg. Dist. No. 104

1. PLACE OF DEATH:

County Charles
 City or town Rural - Tompkinsville
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Charles
 City or town Rural - Tompkinsville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Windmill Point - Williams Road
 (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Richard Allan Jackson

3.(b) Social Security Number

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Single6.(b) Name of husband or wife Father Francis Victor Jackson

7. Birth date of deceased (mo., day, yr.)

Sept. 27, 19445.(c) If alive, give age 37 years

8. AGE:

Years

Months

Days

If less than one day

334

hrs.

min.

9. Birthplace

Providence Hospital, Wash. DC.
(Town, county, and state)

10. Usual occupation

child

11. Industry or business

FATHER

12. Name

Francis Victor Jackson

13. Birthplace

Hagerstown, Md.

MOTHER

14. Maiden name

Elsie Michael

15. Birthplace

Washington, D.C.

16. Informant

Bathston Jackson

Address

Tompkinsville, Md.

17.

Burial
(Burial, cremation, or removal, Which?)

Date thereof

1/3/48
(month) (day) (year)

Cemetery or crematory

Holy Ghost

Location

Isisue Md.

18. Funeral director

Wm. J. Ryan

Address

Wardoff, Md.

19.

1/2 19 48
(Date rec'd by registrar)William J. Ryan
Registrar

MEDICAL CERTIFICATION

EST

20. DATE OF DEATH

1st January 19 48 at 12:30p. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1-1- 19 48 to 1-1- 19 48and that I last saw him alive on 1-1- 19 48

Immediate cause of death

Convulsions

DURATION

10 mins.

Due to

Indigestion

DURATION

1 day

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

J. L. Higdon

M. D. or other

Address

WaysideDate signed 1-2-48

RECEIVED
JAN 5 1948
BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00432

Reg. Dist. No. 100

1. PLACE OF DEATH:

County... Charles
 City or town... La Plata
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 days
 Hospital, institution, or street address where death occurred:
Physicians' Memorial Hospital
 How long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State... MD County... Charles
 City or town... Rock Point
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)
 2.(a) If veteran, name war.

3. (a) FULL NAME

Eugene Lloyd Lacey

3. (b) Social Security Number

4. Sex M 5. Color or race W 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife Mary Beatrice Lacey
 6.(c) If alive, give age years
 7. Birth date of deceased (mo., day, yr.) Dec. 9, 1909
 8. AGE: Years 38 Months 26 Days hrs. min.

9. Birthplace... St. Mary's co. md.
 (Town, county, and state)

10. Usual occupation... Laborter

11. Industry or business

FATHER 12. Name James M. Lacey
 13. Birthplace St. Mary's co. md.

MOTHER 14. Maiden name Aligail Ferrall
 15. Birthplace St. Mary's co. md.

16. Informant Mrs. Beatrice Lacey
 Address Rock Point, md.

17. Burial, cremation, or removal, Which? Burial Date thereof 1/6/48
 (month) (day) (year)
 Cemetery or crematory Holy Ghost
 Location Isside, md.

18. Funeral director H. Smith & Ryan
 Address Waldorf, md.

19. 1-6 48 Julius H. Porey
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... 1-3 19 48, at 12:30 P.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12-27 19 47 to 1-3 19 48
 and that I last saw him 2 alive on 1-2 19 48

Immediate cause of death... Septicemia
 Due to... Pneumococcus Pneumonia
 Due to...
 Other conditions Pericarditis
 (Include pregnancy within 3 months of death)

DURATION

12-27-47
12-30-47

Major findings of operations... Date of op.

Autopsy results...
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
 Accident, suicide, or homicide... Date of ...
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE E. Redman N.J.
 Address La Plata Date signed 1-3-48

RECEIVED
JAN 17 1948
FT. BELLE

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH:

County CharlesCity or town La Plata
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md. County CharlesCity or town La Plata
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Francis Brooke Matthews

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Annie Cassin (Joss) Matthews6. (c) If alive, give age 71 years

7. Birth date of

deceased (mo., day, yr.)

Aug. 4, 1866

8. AGE:

Years

Months

Days

If less than one day

81517

hrs.

min.

9. Birthplace

St. Mary's Co., Md.
(Town, county, and state)

10. Usual occupation

Real estate agent

11. Industry or business

FATHER

12. Name James Francis Matthews13. Birthplace St. Mary's Co., Md.

MOTHER

14. Maiden name Victoria Rust15. Birthplace St. Mary's Co., Md.16. Informant (Mrs.) Catherine Martin (daughter)Address 816 - Mississippi Ave., Chattanooga, Tenn.17. Burial
(Burial, cremation, or removal. Which?)Date thereof 1-24-48
(month) (day) (year)Cemetery or crematory St. IgnaceLocation Bel. altar Md.18. Funeral director Hurt & RyonAddress Wall of Md.19. 1-22 19 48
(Date rec'd by registrar)Julia H. Posey
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 21, 1948 at 2:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

December 6, 1947 to Jan 21, 1948and that I last saw him alive on January 15, 1948

Immediate cause of death

Coronary thrombosis (2nd attack)

DURATION

Minutes

Due to

Coronary artery disease2-3 yrs.

Due to

Generalized arteriosclerosis2-3 yrs.Other conditions Coronary thrombosis642 who previously

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op. _____

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of _____

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

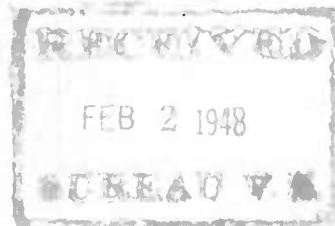
Injured at work?

23. SIGNATURE

James E. McKenney, M.D.

M. D. or other

Address La Plata, Md. Date signed 1-21-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County CharlesCity or town Malcolm
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 49

Hospital, institution, or street address where death occurred:

How long in hospital or institution? Malcolm

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County CHARLESCity or town MALCOLM
(If outside city or town limits, write RURAL and give nearest town)Street No. MALCOLM - NEAR GALLANT GREEN
(If rural, give LOCATION)2.(a) If veteran, name war NONE

3. (a) FULL NAME

CHARLES DEWAN MORELAND

3. (b) Social Security Number

4. Sex

M

5. Color or race

WHITE

6. (a) Single, married, widowed, or divorced

SINGLE

6. (b) Name of husband or wife

NONE

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.)

OCT. 13, 1900

8. AGE:

Years 48Months 3Days 15

If less than one day

hrs.

min.

9. Birthplace

GALLANT GREEN, CHARLES MD
(Town, county, and state)

10. Usual occupation

FARMER

11. Industry or business

FATHER

12. Name

GEORGE H. MORELAND

13. Birthplace

GALLANT GREEN, MD

MOTHER

14. Maiden name

MARY C. MONTGOMERY

15. Birthplace

GALLANT GREEN, MD

16. Informant

GEORGE E. MORELAND, BROTHER

Address

WALDORF, MD17. Burial
(Burial, cremation, or removal. Which?)

Date thereof

1-31-49
(month) (day) (year)

Cemetery or crematory

St. Peters

Location

Wardway and

18. Funeral director

Smith & Son

Address

Wardway and19. 1-31
(Date rec'd by registrar)

19

49 M R. Moore
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH JANUARY 29, 1948 at 2 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

DECEMBER 19, 48 to JAN 49and that I last saw him alive on JAN 27 1949Immediate cause of death CEREBRALANEMIA

DURATION

Due to CARDIOVASCULARCOLLAPSEDue to TUBERCULOSIS,PULMONARY, BILATERAL

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Alfred R. Laper, MD
M.D. or otherAddress Agassiz, Md Date signed Jan 30, 1949

RECEIVED

FEB 1 1949

BUREAU Y. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of
age shown on:

FILM No. G 11 MAY 4 - 1948

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 105

1. PLACE OF DEATH:

County CHARLES
City or town WALDORF
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 1/2 yrs 8 mo.
Hospital, institution, or street address where death occurred:
HOME
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Charles
City or town Rural Waldorf, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. —
(If rural, give LOCATION)
2. (a) If veteran, name war —

3. (a) FULL NAME

HENRY PLOOR

3. (b) Social Security Number

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced M

6. (b) Name of husband or wife LUCY PLOOR

6. (c) If slave, give age 74 years

7. Birth date of deceased (mo., day, yr.) July 8 1869

8. AGE: Years 78 77 Months 6 Days 13 If less than one day — hrs. — min.

9. Birthplace RACINE Wisconsin
(Town, county, and state)

10. Usual occupation FARMING

11. Industry or business

12. Name William Ploor

13. Birthplace Mid-ocean

14. Maiden name TERESA FEAST

15. Birthplace Biden, GERMANY

16. Informant Lucy Ploor

Address Waldorf, Maryland

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof 1/24/48
(month) (day) (year)

Cemetery or crematory St. Agnes

Location Sellersville Pa.

18. Funeral director Hunt & Ryan

Address Waldorf, Md.

19. 1-21 48 MD Waldorf
(Date rec'd by registrar) (Year) (Month) (Day)

MEDICAL CERTIFICATION

20. DATE OF DEATH JAN 21 1948, at 5:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from OCTOBER 17 to JANUARY 19 1948 and that I last saw him alive on JAN 20 1948

Immediate cause of death CARDIAC COLLAPSE DURATION —

Due to CARDIOVASCULAR DISEASE

Due to GENERALIZED ARTERIOSCLEROSIS

Other conditions —
(Include pregnancy within 8 months of death)

Major findings of operations — Date of op. —

Autopsy results —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of —

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work? —

23. SIGNATURE Alfred R. Lape, M.D. M.D. or other —
Address Agassiz, Md. Date signed Jan 21, 1948

RECORDED
JAN 23 1948
INDEXED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Mrs. Harney Stine

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00434

Reg. Dist. No. *104*

1. PLACE OF DEATH:

County *Charles*
City or town *Rural Rock Point, Md.*
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Agnes B. Stine

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Md.* County *Charles*
City or town *Rock Point, Md.*
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____
(If rural, give LOCATION)

2. (a) If veteran, name war _____

3. (b) Social Security Number

4. Sex

Female

5. Color of race

W

6. (a) Single, married, widowed, or divorced

Married.

6. (b) Name of husband or wife

Harney Stine

7. Birth date of deceased (mo., day, yr.)

Nov. 19, 1914

6. (c) If alive, give age _____ years

8. AGE:

Years

Months

Days

It less than one day

33

2

hrs.

min.

9. Birthplace

Alexandria Va.
(Town, county, and state)

10. Usual occupation

Housework

11. Industry or business

Louis E. Haugh

MOTHER FATHER

12. Name

Louis E. Haugh

13. Birthplace

Va.

14. Maiden name

Ellen R. Halls

15. Birthplace

Va.

18. Informant

Address

Harney Stine
Rock Point, Md.

17. (Burial, cremation, or removal, which?)

Cemetery or crematory

Location

18. Funeral director

Address

Burial
Date thereof *1/20/48*
(month) (day) (year)
Sally Ghost
Isse, Md.
Wentt & Ryan
Waldorf, Md.

19. (Date rec'd by registrar)

1/19 48

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *18 January* 19 *48* at *5:30 A.M.*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

29 November 19 *47* to *18 Jan* 19 *48*

and that I last saw her *14 January* 19 *48*

Immediate cause of death *Congestive*

DURATION

1/2 hour

Due to *Myocardial Degeneration*

year

Due to *Cause Unknown*

unknown

Other conditions *None. Congestive*

heart failure
(Include pregnancy within 8 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE

Dr. Woody M.D. or other
Address *Box 214 La Plata, Md.* Date signed *18 Jan 48*

RECEIVED

JAN 23 1948

BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 00435,000

1. PLACE OF DEATH:

County... Charles
City or town... La Plata
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State... MD. County... Charles
City or town... La Plata
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2. (a) If veteran, name war

3. (a) FULL NAME

William Edward Williams

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
6. (b) Name of husband or wife Annie T. (Olson) Williams
6. (c) If alive, give age... years
7. Birth date of deceased (mo., day, yr.) Jan. 28, 1866
8. AGE: Years 82 Months 0 Days 1 If less than one day... hrs. min.

9. Birthplace... Patuxent City, Charles, Md.
(Town, county, and state)
10. Usual occupation... Bricklayer
11. Industry or business
12. Name... William Wallace Williams
13. Birthplace... ?
14. Maiden name... Nellie Sharpe
15. Birthplace... ?

16. Informant... Mrs. Annie Williams
Address... La Plata, Md.
17. Burial Date thereof... 2-3-48
(Burial, cremation, or removal, Which?) (month) (day) (year)
Cemetery or crematory... Trinity
Location... Newport, Md.
18. Funeral director... Hunt & Ryan
Address... Waldorf, Md.
19. 131 8:8 Julia H. Perry
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... January 29, 1948 at 1:42 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from... 1936 to Jan 29, 1948
and that I last saw him alive on January 29, 1948
Immediate cause of death... Acute pyelonephritis with uremia DURATION 8 days
Due to... Benign prostatic hypertrophy 12-15 yrs.
Due to...
Other conditions... Chronic cholecystitis + cholangitis 12 yrs
Congestive heart failure 3 yrs.
(Include pregnancy within 3 months of death)
Major findings of operations...
Date of op. ...
Autopsy results...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide... Date of...
Where did injury occur? X (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?
23. SIGNATURE... James S. MacKavanagh, M.D. M. D. or other
Address... La Plata, Md. Date signed... 1-29-48

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

